

be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it shall be filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

3405

03363

1. PLACE OF DEATH a. COUNTY <b>HOWARD</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>HOWARD</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>JESSUPS</b>				c. LENGTH OF STAY IN 1b <b>45 yrs</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>OAK HILL</b>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>SIDNEY RILEY ADAMS</b>				4. DATE OF DEATH Month Day Year <b>Mar 3 1960</b>			
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>NOV. 8 - 1887</b>	
9. AGE (In years lost birthday) <b>72</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSE WIFE</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>		11. BIRTHPLACE (State or foreign country) <b>BALTIMORE</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>CHARLES RILEY</b>				14. MOTHER'S MAIDEN NAME <b>LAURA SIMMONS</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NO</b>		17. INFORMANT Address <b>MRS SIDNEY A. WILSON 14821 LAY HILL ROAD SILVER SPRING, MD.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>3. Cardio Vascular Disease</b> 420.1 DUE TO <b>2c. Pulmonary Congestion</b> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. <b>1. Coronary Heart Disease</b> (c) <b>4. Hypertensive Pathosis</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>5. Atherosclerosis</b> INTERVAL BETWEEN ONSET AND DEATH <b>3 yrs 2 days</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Sept 1959</b> to <b>March 3, 1960</b> that (I) (we) last saw the deceased alive on <b>March 2, 1960</b> and that death occurred at <b>8:30 M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>B B Brumbaugh</b> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>3/4/60</b>	
22c. PHYSICIAN'S NAME (Type) <b>B B Brumbaugh</b>				22d. ADDRESS <b>3609 Manor Dr Elbridge 27 Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Mar 7/60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>London Park Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Baltimore Md</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Henry W. Jenkins &amp; Sons Co.</b> ADDRESS <b>4905 York Road</b>				25a. REC'D BY REGISTRAR DATE <b>MAR 7 '60</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>	

CERTIFICATE OF DEATH

1. Name of Deceased		2. Sex		3. Age	
4. Date of Death		5. Time of Death		6. Place of Death	
7. Cause of Death		8. Manner of Death		9. Signature of Registrar	
10. Signature of Medical Officer		11. Signature of Coroner		12. Signature of Police Officer	
13. Signature of Burial Officer		14. Signature of Undertaker		15. Signature of Witness	
16. Signature of Family Member		17. Signature of Friend		18. Signature of Neighbor	
19. Signature of Clergyman		20. Signature of Minister		21. Signature of Chaplain	
22. Signature of Priest		23. Signature of Rabbi		24. Signature of Imam	
25. Signature of Other Religious Leader		26. Signature of Other Religious Leader		27. Signature of Other Religious Leader	
28. Signature of Other Religious Leader		29. Signature of Other Religious Leader		30. Signature of Other Religious Leader	
31. Signature of Other Religious Leader		32. Signature of Other Religious Leader		33. Signature of Other Religious Leader	
34. Signature of Other Religious Leader		35. Signature of Other Religious Leader		36. Signature of Other Religious Leader	
37. Signature of Other Religious Leader		38. Signature of Other Religious Leader		39. Signature of Other Religious Leader	
40. Signature of Other Religious Leader		41. Signature of Other Religious Leader		42. Signature of Other Religious Leader	
43. Signature of Other Religious Leader		44. Signature of Other Religious Leader		45. Signature of Other Religious Leader	
46. Signature of Other Religious Leader		47. Signature of Other Religious Leader		48. Signature of Other Religious Leader	
49. Signature of Other Religious Leader		50. Signature of Other Religious Leader		51. Signature of Other Religious Leader	
52. Signature of Other Religious Leader		53. Signature of Other Religious Leader		54. Signature of Other Religious Leader	
55. Signature of Other Religious Leader		56. Signature of Other Religious Leader		57. Signature of Other Religious Leader	
58. Signature of Other Religious Leader		59. Signature of Other Religious Leader		60. Signature of Other Religious Leader	
61. Signature of Other Religious Leader		62. Signature of Other Religious Leader		63. Signature of Other Religious Leader	
64. Signature of Other Religious Leader		65. Signature of Other Religious Leader		66. Signature of Other Religious Leader	
67. Signature of Other Religious Leader		68. Signature of Other Religious Leader		69. Signature of Other Religious Leader	
70. Signature of Other Religious Leader		71. Signature of Other Religious Leader		72. Signature of Other Religious Leader	
73. Signature of Other Religious Leader		74. Signature of Other Religious Leader		75. Signature of Other Religious Leader	
76. Signature of Other Religious Leader		77. Signature of Other Religious Leader		78. Signature of Other Religious Leader	
79. Signature of Other Religious Leader		80. Signature of Other Religious Leader		81. Signature of Other Religious Leader	
82. Signature of Other Religious Leader		83. Signature of Other Religious Leader		84. Signature of Other Religious Leader	
85. Signature of Other Religious Leader		86. Signature of Other Religious Leader		87. Signature of Other Religious Leader	
88. Signature of Other Religious Leader		89. Signature of Other Religious Leader		90. Signature of Other Religious Leader	
91. Signature of Other Religious Leader		92. Signature of Other Religious Leader		93. Signature of Other Religious Leader	
94. Signature of Other Religious Leader		95. Signature of Other Religious Leader		96. Signature of Other Religious Leader	
97. Signature of Other Religious Leader		98. Signature of Other Religious Leader		99. Signature of Other Religious Leader	
100. Signature of Other Religious Leader		101. Signature of Other Religious Leader		102. Signature of Other Religious Leader	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S)  
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3407

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03364

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>HOWARD.</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>HOWARD</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>DAYTON</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>DAYTON</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>rural</b>				d. STREET ADDRESS <b>rural</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Robert</b> Middle <b>Cox</b> Last <b>Day</b>				4. DATE OF DEATH Month <b>March</b> Day <b>15</b> Year <b>1960</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 23, 1915</b>	
9. AGE (In years last birthday) <b>44 yrs.</b>		10. UNDER 1 YEAR Months <b>44</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>		11. BIRTHPLACE (State or foreign country) <b>Dayton, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>House Constr.</b>		11. BIRTHPLACE (State or foreign country) <b>Dayton, Maryland</b>	
13. FATHER'S NAME <b>Elmon Day</b>				14. MOTHER'S MAIDEN NAME <b>Beulah Johnson</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>213 16 6065</b>		17. INFORMANT Address <b>Mrs. Betty Day (wife), Dayton, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Asphyxia</b> <b>974X</b> DUE TO <b>Hanging.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Hanged self.</b>					
20c. TIME OF INJURY Hour <b>3:00</b> p. m. <b>3/15</b> 19 <b>60</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Shed rear of Home</b>		20f. (City or town) (County) (State) <b>Dayton Howard Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>Charles S. Petty</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>Charles S. Petty, M.D.</b>				DATE SIGNED <b>3/16/60</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3-19-60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Providence</b>		22d. LOCATION (City, town, or county) (State) <b>Glenelg, Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>F.C. Higinbotham, Ellicott City, Md</b>				ADDRESS		24a. REC'D BY REGISTRAR DATE <b>MAR 18 '60</b>	
						24b. REGISTRAR'S SIGNATURE <b>Carlton S. Hume</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, the registrars should be retained by the hospital or attending physician. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3400

## CERTIFICATE OF DEATH

03365

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Howard</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Balto.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ellicott City</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Middle River, Md</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Schaefer Convelescent Home</b>		d. STREET ADDRESS <b>401 Kingston Road</b>	
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>E.</b> Last <b>Fosbender</b>		4. DATE OF DEATH Month <b>March</b> Day <b>25</b> Year <b>19 60</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>About 84 yrs</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Baltimore, Md</b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>James J. Flannery</b>		14. MOTHER'S MAIDEN NAME <b>Eliza Copeland</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>James H. Gorges</b>		Address <b>211 Redwood Street</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia</b> <b>493X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>2 da</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>2-27</b> , 19 <b>60</b> , to <b>3-25</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>3-24</b> , 19 <b>60</b> , and that death occurred at <b>9 P. M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>46 Church Road</b> DATE SIGNED <b>3.28.60</b> ACTUAL SIGNATURE <b>Thomas F. Herbert</b> M.D. PHYSICIAN'S NAME (Type) <b>Thomas F. Herbert, M.D.</b> <b>Ellicott City, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3/28/60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>H. W. Means &amp; Son 805 N. Calvert St</b>		24a. REC'D BY REGISTRAR DATE <b>MAR 30 '60</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>			

CERTIFICATE OF DEATH

1900

Age at Death

Place of Birth

Occupation

Color

Signature of Physician

Signature of Registrar

Signature of Coroner

Signature of Medical Examiner

Signature of Undertaker

Signature of Burial Place

Signature of Family

Signature of Church

Signature of Friends

Signature of Community

Signature of Neighbors

Signature of Society

Signature of Clergy

Signature of Government

Signature of State

Signature of Nation

Signature of World

Signature of Universe

Signature of Time

Signature of Space

Signature of Matter

Signature of Energy

Signature of Life

Signature of Death

Signature of Birth

Signature of Burial

Signature of Cremation

Signature of Interment

Signature of Disposition

Signature of Final Rest

Signature of Eternal Peace

Signature of Lasting Memory

Signature of Everlasting Love

Signature of Unending Hope

Signature of Infinite Grace

Signature of Divine Mercy

Signature of Heavenly Father

Signature of Holy Spirit

Signature of Jesus Christ

Signature of Blessed Virgin

Signature of All Saints

Signature of Holy Angels



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it shall be filled in by the funeral director,  
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03366

3468

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Howard</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural- Glenwood</b> c. LENGTH OF STAY IN lb <b>Life</b> d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Hobbs Rd.</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Howard</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural- Glenwood</b> d. STREET ADDRESS <b>Hobbs Road</b> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>Charles</b> First <b>A.</b> Middle <b>Hobbs</b> Last <b>-H</b>		4. DATE OF DEATH <b>March</b> Month <b>8</b> Day <b>1960</b> Year				
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 22, 1898</b>	9. AGE (In years last birthday) <b>61</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer Owner</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Charles A. Hobbs 11</b>		14. MOTHER'S MAIDEN NAME <b>Mary V. Dorsey</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>214-28-5943</b>		INFORMANT <b>Eliza Riggs Hobbs, Glenwood, Md.</b> Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>163X</b> DUE TO <b>Cardio-Respiratory failure</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Dehydration + Malnutrition</b> (c) <b>Carcinoma of Lung.</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <b>3 months</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>June</b> , 19 <b>59</b> , to <b>8 March</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>8 March</b> , 19 <b>60</b> , and that death occurred at <b>2:55 PM</b> , from the causes and on the date stated above.						
ACTUAL SIGNATURE <b>William J. Bryson</b>		ADDRESS (Street, city or town, state) DATE SIGNED <b>4605 Edmondson Ave 9 March 1960</b>				
PHYSICIAN'S NAME (Type) <b>William J. Bryson</b>		<b>Balto 29, Md.</b>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3-10-1960</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Oak Grove Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Howard Co. Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>C. M. Waltz, Winfield, Maryland</b>		ADDRESS <b>Winfield, Maryland</b>		24a. REC'D BY REGISTRAR DATE <b>MAR 10 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hinkle</b>

CERTIFICATE OF DEATH

3407

Howard

Maryland

Howard

Howard

Howard

Howard

Howard

Howard

Howard

Howard

Howard

Howard

Howard

Howard



## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Howard</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Howard</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Clarksville</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Clarksville</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <b>1</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>SARAH JANE HOBBS</b>				4. DATE OF DEATH Month <b>March</b> Day <b>27</b> Year <b>1960</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Nov. 7, 1861</b>	
9. AGE (In years last birthday) <b>98</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>At Home</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Alpha, Maryland</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>John R. Williams</b>				14. MOTHER'S MAIDEN NAME <b>Mary Johns</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		INFORMANT <b>Miss Lura Hobbs, Clarksville, Md</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic myocardial failure</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic heart disease</b> DUE TO (c) <b>25 years</b>						INTERVAL BETWEEN ONSET AND DEATH <b>5 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July 1946</b> to <b>March 27, 1960</b> , that I last saw the deceased alive on <b>March 27, 1960</b> , and that death occurred at <b>12 noon</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <b>Charles S. Whitaker, M.D.</b>							
PHYSICIAN'S NAME (Type) <b>Charles S. Whitaker, M.D.</b>		<b>Clarksville, Md.</b>		<b>3-28-60</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3-30-60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. Marks</b>		22d. LOCATION (City, town, or county) (State) <b>Highland, Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>F.C. Higinbotham, Ellicott City, Md</b>				24a. REC'D BY REGISTRAR DATE <b>MAR 29 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arina E. H...</b>	

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MARYLAND STATE DEPARTMENT OF HEALTH  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

03368

CERTIFICATE OF DEATH

3410 Item 14 Film G266 Item 14 Film G266 3-30-60 et

1. PLACE OF DEATH a. COUNTY <u>HOWARD</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>JESSUPS Md</u> c. LENGTH OF STAY IN lb <u>30 yrs</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>JESSUPS R.F.D</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>HOWARD</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>JESSUPS Md</u> d. STREET ADDRESS <u>JESSUPS R.F.D</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>AMOS</u> First <u>E</u> Middle <u>HOLLAND</u> Last 4. DATE OF DEATH <u>MARCH 16 1960</u> Month <u>16</u> Day <u>1960</u> Year		5. SEX <u>MALE</u> 6. COLOR OR RACE <u>COLORED</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>SEPT 2 1891</u> 9. AGE (In years last birthday) <u>68</u> yrs. IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>STATE ROADS COMM LABORER</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Md</u> 11. BIRTHPLACE (State or foreign country) <u>Md</u> 12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <u>JOHN HOLLAND</u> 14. MOTHER'S MAIDEN NAME <u>MARY CHARLOTTE Matthews</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> <u>1917</u> (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. <u>212-18-82</u> 17. INFORMANT <u>WILLIAM HOLLAND JESSUPS Md</u> Address <u>IR</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>442X</u> <u>Arteriosclerotic C.V.R. Disease</u> DUE TO <u>Generalized Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>8 yrs.</u> DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Asthmatic Bronchitis</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 <u>7/9</u> 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>7/9</u> 19 <u>60</u> <u>3/16</u> 19 <u>60</u> , that (I) (we) last saw the deceased alive on <u>3/16</u> 19 <u>60</u> and that death occurred at <u>4A</u> M, from the causes and on the date stated above. 22a. SIGNATURE <u>J M Warren</u> M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22c. PHYSICIAN'S NAME (Type) <u>Laurel Md</u> 22d. ADDRESS <u>Laurel Md</u>		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>Mar 19, 1960</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Ashbury</u> 23d. LOCATION (City, town, or county) (State) <u>Howard near Savage Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Ridgely Selby Laurel Md</u> ADDRESS <u>Laurel Md</u> 25a. REC'D BY REGISTRAR <u>Arthur S. Krand</u> DATE <u>MAR 22 '60</u> 25b. REGISTRAR'S SIGNATURE			

MEDICAL CERTIFICATION



## CERTIFICATE OF DEATH

Reg. Dist. No.

03369

3401

1. PLACE OF DEATH o. COUNTY <b>Howard</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Howard</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ellicott City</b>		c. LENGTH OF STAY IN lb <b>Ellicott City</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Pine Orchard</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>MARGARET L. KIRN</b>		4. DATE OF DEATH Month Day Year <b>March 31, 1960 19</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 4, 1884</b>
9. AGE (In years last birthday) <b>75</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>At Home</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (State or foreign country) <b>Pine Orchard, Md</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Charles A. Gerwig</b>		14. MOTHER'S MAIDEN NAME <b>Barbara Hagan</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Mrs. Donald E. Fisher, Ellicott City, Md</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Right Cerebral artery disease</b> <b>332x</b> DUE TO <b>(Probably Thrombotic); recurrent.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <b>2 years</b>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Oct 19 59</b> to <b>Mar 31 1960</b> that I last saw the deceased alive on <b>Mar 30 1960</b> , and that death occurred at <b>3:45</b> M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Robert B. Taylor</b>		DATE SIGNED <b>111 Columbia Rd. Ellicott City, Md.</b>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>4-2-60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>St. Johns</b>	22d. LOCATION (City, town, or county) (State) <b>Ellicott City, Md</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>F.C. Higinbotham, Ellicott City, Md</b>		24a. REC'D BY REGISTRAR DATE <b>APR 4 '60</b>	
		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





3402

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Howard</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ellicott City</b>				c. LENGTH OF STAY IN 1b <b>17 days</b>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore 18</b>				3401.4			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Taylor Manor Hospital</b>				d. STREET ADDRESS <b>Greenway Aptmts. 34 &amp; Charles</b>			
e. IS RESIDENCE ON A FARM? <input checked="" type="checkbox"/> NO <input type="checkbox"/> YES							
3. NAME OF DECEASED (Type or print) First <b>Henrietta</b> Middle <b>Baker</b> Last <b>Low</b>				4. DATE OF DEATH Month <b>March</b> Day <b>9th</b> Year <b>19 60</b>			
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 27 1868</b>		9. AGE (In years last birthday) <b>91</b> yrs.	IF UNDER 1 YEAR Months <b>2</b> Days <b>11</b> Hours <b>00</b> Min. <b>00</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Teacher of music</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>School</b>		11. BIRTHPLACE (State or foreign country) <b>Harford County</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Conrad Baker</b>				14. MOTHER'S MAIDEN NAME <b>Henrietta</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>(If yes, give war or dates of service)</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Helen G. Smith, niece, Easton, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> <b>422.2</b> DUE TO <b>Myocardial Heart Failure</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Cerebral Arteriosclerosis, senile Brain disease.</b>						INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>5 days</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Febr. 21</b> , 19 <b>60</b> , to <b>March 9</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>March 9</b> , 19 <b>60</b> , and that death occurred at <b>12<sup>00</sup> P</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Taylor Manor Hospital</b> DATE SIGNED <b>3-10-60</b>							
ACTUAL SIGNATURE <b>Stephen Lee Magness</b> M.D.							
PHYSICIAN'S NAME (Type) <b>Stephen Lee Magness, M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3-11-60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Greenmount</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John O. Mitchell &amp; Sons, Inc. 1900 Eutaw Place</b>				24a. REC'D BY REGISTRAR DATE <b>MAR 14 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. [unclear]</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES H. HARRIS		2. SEX Male	
3. AGE 65		4. DATE OF BIRTH 1875	
5. PLACE OF BIRTH BALTIMORE, MARYLAND		6. OCCUPATION Carpenter	
7. MARITAL STATUS Married		8. PLACE OF DEATH Home	
9. DATE OF DEATH 1942		10. TIME OF DEATH 10:30 AM	
11. CAUSE OF DEATH Heart Disease		12. MANNER OF DEATH Natural	
13. SIGNATURE OF PHYSICIAN J. H. HARRIS		14. SIGNATURE OF WITNESSES J. H. HARRIS	
15. SIGNATURE OF REGISTRAR J. H. HARRIS		16. SIGNATURE OF CLERK J. H. HARRIS	

CERTIFICATE OF DEATH

3403

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Howard MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 30 3401.4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Taylor Manor Hospital		d. STREET ADDRESS 2806 Maisel Str. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <del>Reese</del> First Aquila Middle A. --- Last Reese		4. DATE OF DEATH Month March Day 31 Year 1960	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5 - 8 - 1903
9. AGE (In years last birthday) 56		10. IF UNDER 1 YEAR Months 10 Days 22 Hours 4 Min 45	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Crane Operator		10b. KIND OF BUSINESS OR INDUSTRY Revere Copper & Brass Company	
11. BIRTHPLACE (State or foreign country) Baltimore		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Aquila A. Reese Sr.		14. MOTHER'S MAIDEN NAME Sarah	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. V	
17. INFORMANT Wife Rona M. Reese		Address Baltimore 30, 2806 Maisel	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) --- (c) Cerebral Arteriosclerosis unknown		INTERVAL BETWEEN ONSET AND DEATH 4-6	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Brain Syndrome with Psychosis and with Cerebral Arteriosclerosis			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan. 28 th 1960 to March 31st, 1960, that I last saw the deceased alive on March 31, 1960, and that death occurred at 4:55 A.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE Irving J. Taylor		ADDRESS (Street, city or town, state) Taylor Manor Hospital DATE SIGNED 3-31-60	
PHYSICIAN'S NAME (Type) Irving J. Taylor, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF April 2/60	22c. NAME OF CEMETERY OR CREMATORY New Cathedral	22d. LOCATION (City, town, or county) (State) Baltimore 29, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Witzke F. D., 4101 Edmondson Ave.		24a. REC'D BY REGISTRAR DATE APR 1 '60 24b. REGISTRAR'S SIGNATURE Arthur L. Thomas	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate is retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPT. OF TRANSPORTATION

3411  
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Howard</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dayton</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Howard</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dayton</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>ERMA WILDERING ROGERS</b>		4. DATE OF DEATH Month Day Year <b>March 16, 1960 19</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 19, 1878</b>	9. AGE (In years lost birthday) yrs. <b>81</b>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>At Home</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>North Carolina</b>	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <b>Edwin Walker</b>		14. MOTHER'S MAIDEN NAME <b>Dolly Hawkins</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>None</b>		INFORMANT Address <b>Mrs. John Fyock, Dayton, Md</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute cardiac failure</b> <b>420.0</b> DUE TO Arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH <b>12 hrs.</b> <b>20 years.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan. 24, 1955</b> to <b>March 16, 1960</b> , that I last saw the deceased alive on <b>March 16, 1960</b> , and that death occurred at <b>7:15 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>Charles S. Whitaker, M.D. Clarksville, Md. Mar. 16, '60</b>					
ACTUAL SIGNATURE <b>Charles S. Whitaker</b>					
PHYSICIAN'S NAME (Type) <b>Charles S. Whitaker, M.D. Clarksville, Md. Mar. 16, '60</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>March 19, 1960</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park</b>	
22d. LOCATION (City, town, or county) (State) <b>Baltimore Md</b>		23. FUNERAL DIRECTOR'S SIGNATURE <b>F.C. Higinbotham, Ellicott City, Md</b>		24a. REC'D BY REGISTRAR DATE <b>MAR 18 '60</b>	
24b. REGISTRAR'S SIGNATURE <b>Charles S. Whitaker</b>					

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
ISM 9/58

DATE OF RECEIPT

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained in your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

03373

1. PLACE OF DEATH a. COUNTY <u>Howard</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Howard</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ellicott City</u>		c. LENGTH OF STAY IN TB	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>73 New Cut Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>WILLIAM TYLER SCOTT</u>		4. DATE OF DEATH Month Day Year <u>Mar. 31, 1960</u> 19	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-22-1902</u>
9. AGE (In years last birthday) <u>57</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Ellicott City, Md</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Samuel Scott</u>		14. MOTHER'S MAIDEN NAME <u>Carrie Ward</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Rebecca Scott, Ellicott City, Md</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Atherosclerosis</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>10 Min.</u> <u>5 years</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Thomas F. Herbert</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Thomas F. Herbert M D</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>3-31-60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4-5-60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Western Star</u>		22d. LOCATION (City, town, or county) (State) <u>Catonsville, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F.C. Higinbotham, Ellicott City, Md</u>		24a. REC'D BY REGISTRAR DATE <u>APR 4 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Knaus</u>			

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Form No. 10

1. NAME OF DECEASED WILLIAM YOUNG 2007		2. SEX Male	
3. AGE 22 years 0 months 0 days		4. RACE White	
5. DATE OF DEATH May 1, 1902		6. PLACE OF DEATH City of Baltimore	
7. TIME OF DEATH 10:00 AM		8. CAUSE OF DEATH Typhoid fever	
9. MANNER OF DEATH Natural		10. SIGNATURE OF EXAMINER J. Edgar Hoover	
11. SIGNATURE OF NEXT OF KIN John A. Young		12. SIGNATURE OF PHYSICIAN J. Edgar Hoover	
13. SIGNATURE OF BURIAL OFFICIAL J. Edgar Hoover		14. SIGNATURE OF CLERK J. Edgar Hoover	
15. SIGNATURE OF WITNESS J. Edgar Hoover		16. SIGNATURE OF WITNESS J. Edgar Hoover	
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3412

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <del>XXXXXXXXXX</del> Howard MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY <del>XXXXXXXXXX</del> Howard	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkridge, Md.		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5827 Virilona Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Anna Middle C. Last Shaab		4. DATE OF DEATH Month March Day 19, Year 19 60	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 7, 1881
9. AGE (In years last birthday) 78 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Elijah Bush		14. MOTHER'S MAIDEN NAME Annie Bowers	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT William A. Shaab		Address 5827 Virilona Ave. #27	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 181.0 DUE TO Carcinoma of Bladder (b) Cordio-Vascular Disease (c) Arterial Hypertension Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that I attended the deceased from July 24, 1960, to Feb 19, 1960, that I last saw the deceased alive on Feb 19, 1960, and that death occurred at 9:15 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE B. Bruce Brumbaugh, M.D. 2/20/60 PHYSICIAN'S NAME (Type) B Bruce Brumbaugh, M. D. 5609 Main Street, Elkridge 27, Md. 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF 3/23/60 22c. NAME OF CEMETERY OR CREMATORY St. Augustines Cem. 22d. LOCATION (City, town, or county) (State) Elkridge, Maryland 23. FUNERAL DIRECTOR'S SIGNATURE Howard H. Hubbard 4107 Wilkens Avenue 24a. REC'D BY REGISTRAR DATE MAR 23 '60 24b. REGISTRAR'S SIGNATURE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

17  
3405  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

03375

1. PLACE OF DEATH a. COUNTY Howard		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City		c. LENGTH OF STAY IN 1b 20 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 12		3401.4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Taylor Manor Hospital				d. STREET ADDRESS 507 Tunbridge Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Edward		Middle Joseph		Last Tully		4. DATE OF DEATH Month March	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2/28/77	
9. AGE (In years last birthday) 83		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) St. Louis, Mo.		12. CITIZEN OF WHAT COUNTRY? U.S.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Auditor				10b. KIND OF BUSINESS OR INDUSTRY Insurance		11. BIRTHPLACE (State or foreign country) St. Louis, Mo.	
13. FATHER'S NAME Michael Joseph Tully				14. MOTHER'S MAIDEN NAME Mary Burke			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO.			
17. INFORMANT Miss Veronica Tully - 507 Tunbridge Rd.				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial failure 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic cardiovascular disease (c) Arteriosclerosis, generalized						INTERVAL BETWEEN ONSET AND DEATH 2 days ? ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Brain Syndrome, senile						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from March 2, 1960, to March 22, 1960, that (I) (we) last saw the deceased alive on March 22, 1960, and that death occurred at 4:10 P.M. from the causes and on the date stated above.							
22a. SIGNATURE Stephen Lee Magness				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 3/22/60	
22c. PHYSICIAN'S NAME (Type) Stephen Lee Magness, M.D.				22d. ADDRESS Taylor Manor Hospital, Ellicott City Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Mar. 25, 1960		23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cem.		23d. LOCATION (City, town, or county) (State) Balto., Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Dickener & Sons - Baltore				25a. REC'D BY REGISTRAR DATE MAR 24 '60		25b. REGISTRAR'S SIGNATURE Christina L. Harris	

00015

DEPARTMENT OF HEALTH  
CENTRAL TO DEATH

1941

Form with multiple lines for text entry, including fields for name, address, and other personal information. The text is mostly illegible due to the quality of the scan.

00015

00015



3413

## CERTIFICATE OF DEATH

03376

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Howard</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural- Mt. Airy</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kempton</b> <b>10X-2</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Day Nursing Home</b>				d. STREET ADDRESS <b>RFD 1 Monrovia</b>			
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>S.</b> Last <b>Watkins</b>				4. DATE OF DEATH Month <b>March</b> Day <b>21</b> Year <b>19 60</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 26, 1881</b>	9. AGE (In years lost birthday) <b>78</b> yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Farmer</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Kempton, Md.</b>	
13. FATHER'S NAME <b>John L. Watkins</b>				14. MOTHER'S MAIDEN NAME <b>Margaret Flood</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>J. Latimer Watkins, Mt. Airy, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Generalized Arteriosclerosis - advanced</b> <b>334X</b> DUE TO <b>with Cerebral Arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>and Arteriosclerotic Heart Disease</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>15 yrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Carcinoma of Prostate Gland</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <b>19</b> p. m.	Month	Day	Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <b>Damascus, Maryland</b>	(County) (State)
21. I certify that I attended the deceased from <b>1935</b> , 19____, to <b>March 21</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>March 21</b> , 19 <b>60</b> , and that death occurred at <b>11:23 a.m.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Damascus, Maryland</b> DATE SIGNED <b>3/22/60</b>							
ACTUAL SIGNATURE <b>M. McKendree Boyer</b> M.D.				DATE SIGNED <b>3/22/60</b>			
PHYSICIAN'S NAME (Type) <b>M. McKendree Boyer</b>				ADDRESS <b>9830 Main Street Damascus, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3/24/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Providence Meth.</b>		22d. LOCATION (City, town, or county) (State) <b>Kempton, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Oliver L. Mohaworth</b>				ADDRESS <b>Damascus, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>MAR 24 '60</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 be retained by the hospital or attending physician.

TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8 Film 259 3-30-60 et

3414

## CERTIFICATE OF DEATH

03377

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Howard City</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>md.</u> b. COUNTY <u>Howard City</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ellicott City</u>		c. LENGTH OF STAY IN IT <u>6 mos.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>St-99-Old Frederick Rd.</u>		d. STREET ADDRESS <u>1 Old Frederick Rd.</u>	
3. NAME OF DECEASED (Type or print) <u>EMMA JEANETTE WEBER</u>		4. DATE OF DEATH Month <u>3</u> Day <u>22</u> Year <u>1960</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 11, 1886</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>DIETITICIAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOSPITAL</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Charles Eidman</u>		14. MOTHER'S MAIDEN NAME <u>Minnie</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO.</u>		16. SOCIAL SECURITY NO. <u>220-12-7427</u>	
17. INFORMANT <u>Robert L. Hancock</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of stomach</u> <u>151X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <u>1 month</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>19</u> to <u>19</u> , that I last saw the deceased alive on <u>19</u> , and that death occurred at <u>9:15 P.</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John M. Gerwig</u> M.D.		ADDRESS (Street, city or town, state) <u>400 Grafton Rd. Balt 28 Md</u> DATE SIGNED	
PHYSICIAN'S NAME (Type) <u>JOHN M. GERWIG JR</u>		<u>* Patient of Dr. George Tenney who saw him 1 week ago. He died of tumor. 3-22-60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-25-60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>London Gate Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Balt</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Forley Funeral Home - Catonsville, Md.</u> ADDRESS		24a. REC'D BY REGISTRAR <u>MAR 24 '60</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Knapp</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

0377

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

CERTIFICATE OF DEATH

WILLIAM BROWN

Name of Deceased		WILLIAM BROWN	
Date of Birth		1910	
Sex		Male	
Race		White	
Marital Status		Single	
Occupation		Student	
Cause of Death		Heart Disease	
Date of Death		1937	
Place of Death		Baltimore, MD	
Signature of Physician		[Signature]	
Signature of Registrar		[Signature]	